UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2022 P 1152-9
Program	Prior Authorization/Notification
Medication	Cosentyx® (secukinumab) prefilled syringe or Sensoready pen
P&T Approval Date	2/2015, 3/2016, 3/2017, 3/2018, 2/2019, 2/2020, 7/2020, 7/2021, 2/2022
Effective Date	5/1/2022; Oxford only: N/A

1. Background:

Cosentyx (secukinumab) is a human interleukin-17A antagonist indicated for the treatment of moderate to severe plaque psoriasis in patients 6 years and older who are candidates for systemic therapy or phototherapy. It is also indicated for the treatment of active psoriatic arthritis (PsA) in patients 2 years of age and older, adults with active ankylosing spondylitis (AS) or non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation. Cosentyx is also indicated for the treatment of active enthesitis-related arthritis (ERA) in patients 4 years of age and older.

2. Coverage Criteria:

A. Plaque Psoriasis

1. **Initial Authorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Diagnosis of moderate to severe plaque psoriasis

-AND-

(2) Patient is not receiving **Cosentyx** in combination with **any** of the following:

(a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)][1]
(b) Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
(c) Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cosentyx therapy

-AND-

(2) Patient is not receiving **Cosentyx** in combination with **any** of the following:

(a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)][1]
(b) Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
(c) Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Authorization will be issued for 12 months.

B. Psoriatic Arthritis

1. **Initial Authorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Diagnosis of active psoriatic arthritis

-AND-

(2) Patient is not receiving **Cosentyx** in combination with **any** of the following:

(a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)][1]
(b) Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
(c) Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cosentyx therapy

-AND-

(2) Patient is not receiving **Cosentyx** in combination with **any** of the following:

(a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)][1]
(b) Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
(c) Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

Authorization will be issued for 12 months.

C. Ankylosing Spondylitis or Non-radiographic Axial Spondyloarthritis

1. **Initial Authorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Diagnosis of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis

-AND-

(2) Patient is not receiving **Cosentyx** in combination with **either** of the following:

(a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)][1]
(b) Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cosentyx therapy

-AND-

(2) Patient is not receiving **Cosentyx** in combination with **any** of the following:

(a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)][1]
(b) Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]

Authorization will be issued for 12 months.

D. Enthesitis-Related Arthritis

1. **Initial Authorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Diagnosis of active enthesitis-related arthritis

-AND-

(2) Patient is not receiving **Cosentyx** in combination with **either** of the following:

(a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)][1]
(b) Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cosentyx therapy

-AND-

(2) Patient is not receiving **Cosentyx** in combination with **any** of the following:

(a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)][1]
(b) Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits and/or Step Therapy may be in place.

4. Reference:

1. Cosentyx [package insert]. East Hanover, NJ. Novartis Pharmaceuticals Corp.; December 2021.

Program	Prior Authorization/Notification - Cosentyx (secukinumab)
Change Control	
2/2015	New program.
3/2016	Annual review. Updated background information and clinical criteria to include the two new indications for active psoriatic arthritis and active ankylosing spondylitis. Added Otezla to the criteria for medications that cannot be used in combination with Cosentyx for plaque psoriasis and psoriatic arthritis. Updated reference.
3/2017	Annual review with no changes to criteria.
3/2018	Annual review with no changes to criteria. Updated reference.
2/2019	Annual review with no changes to criteria. Updated reference.
2/2020	Annual review with no changes to criteria. Updated reference.
7/2020	Updated background and criteria to include new indication for active non-radiographic axial spondyloarthritis. Changed reauthorization duration to 12 months. Updated reference.
7/2021	Annual review. Updated background to include expanded indication for moderate to severe plaque psoriasis to pediatric patients 6 years and older. Updated reference.
2/2022	Updated background and clinical criteria with new indication for ERA. Updated reference.